STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaints IN00091279 and IN00091858. Complaint IN00091279 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323. Complaint IN00091858 - Substantiated. Federal/state deficiencies related to the allegations are cited at and F323 and F328. Survey dates: 6/13 and 6/14/11 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Survey team: Jennie Bartelt, RN Census bed type: SNF: 4 SNF/NF: 119 Total: 123 Census payor type: Medicare: 12 Medicaid: 92 Other: 19 Total: 123	F0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes Lincoln Hills Health Center's allegation of compliance in accordance with Section 7305 in the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sample: 10 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/19/11 Cathy Emswiller RN			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident with multiple falls had increased supervision to prevent further falls for 1 of 5 residents reviewed related to falls with fractures in a sample of 10 residents. (Resident J) Resident J fell and broke his left hip. Upon readmission to the facility, the	F0323	The facility does ensure a resident with multiple falls is provided with the supervision necessary as warranted by their condition and plan of care.Resident J was discharged from the facility on 5/31/11.The care plans for all residents assessed to be at risk for falls have been reviewed by the	07/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident fell three more times, and on the third fall injured the previously fractured hip. Findings include: The closed clinical record for Resident J was reviewed on 6/14/11 at 12:50 p.m. The quarterly Minimum Data Set assessment, dated 4/6/11, indicated in the section for assessment for cognition, the resident did not repeat three words, tell the year, month, or day, or recall three words, and had inattention and disorganized thinking. The resident needed extensive assistance of two staff for bed mobility, transfer, walking, and toilet use. The resident's Care Plan with Problem Onset date of 8/2/10, indicated the resident had "Potential for falls r/t [related to] impaired mobility, unsafe decision making, psychotropic med [medication] use, poor safety awareness." The plan indicated the resident had falls on 9/29/10, 12/20/10, 12/21/10, 1/16/11, 1/18/11, 1/26/11, 3/2/11, 3/21/11, and 4/5/11. A notation on the plan indicated, "rewritten 4/11/11." The resident's Care Plan with Problem Onset date of 4/11/11 and "reviewed		DON. Any necessary changes to interventions and update to the care plan has been completed.The facility does complete an investigation and documentation of each individual fall. However, to enhance our investigation and documentation, a "Quality Assurance Post Fall Investigation" addendum to our incident report has been implemented. All licensed staff have been inserviced regarding utilization of the "Quality Assurance Post Fall Investigation" form and fall prevention measures.Nursing Managers will audit the medical record of each resident sustaining a fall to ensure that the investigation of the fall has been completed and documented and that the care plan has been reviewed and updated as necessary.Findings will be reported to the DON weekly. DON will ensure additional training or counseling is provided as necessary.Findings will be reported to the QA Committee quarterly until such time that the committee deems a reduction in the audits is warranted.DON and Administrator to monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4/25/11" indicated the resident had "Potential for falls r/t [related to] impaired mobility, unsafe decision making, psychotropic med [medication] use, poor safety awareness." The plan indicated the resident had falls on 9/29/10, 12/20/10, 12/21/10, 1/16/11, 1/18/11, 1/26/11, 3/2/11, 3/21/11, 4/5/11, 4/16/11, 5/24/11, and 5/26/11. Printed Approaches on the plan with the goal date of 7/7/11 indicated "Anticipate and meet needs; encourage rest as necessary; ensure non skid footwear when out of bed; W/C for main locomotion; provide and encourage resident to use call light and get assist with ambulation; if resident is restless in bed, staff to assist him to W/C or to bathroom; restorative amb [ambulation] plan [handwritten in]; pressure alarm at all times; gripper socks for preventative measures; notify family and MD of falls; notify therapy and MD of changes in gait PRN [as needed]; Fall Assessment quarterly and PRN; restorative FMP [Functional Maintenance Plan] toileting program per schedule; keep water within reach and offer PRN; encourage resident to sit at nurses station if out of bed; ask res. daily if he wants to get up and respond accordingly; low bed with mat at all times while abed. Nurse's Notes, dated 4/16/11 at 1:30 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, "Nrsg [nursing] staff responded to res alarm. Upon entering room res found lying on L [left] side in BR [bathroom]. Res denies pn [pain] but stated he hit L side of head. Neuro [checks] WNL [within normal limits]. [Symbol for no] apparent injury. Res able to complete full ROM [range of motion] [symbol for without] problem...." Nurse's Notes, dated 4/16/11 at 7:40 p.m., indicated, "N.O. [new order] 30 min [minute] safety [checks] r/t [related to] safety concerns." The order was handwritten onto the Care Plan as a new Approach. Nurse's Notes between 4/16/11 and 4/19/11 indicated the following: the resident's left hip became swollen, and an x-ray was ordered; the x-ray was negative for left hip fracture; the resident began to complain of pain with movement of the left hip and thigh, and a CT scan was ordered and obtained. Nurse's Notes for 4/19/11 at 5:30 p.m., indicated, "Hosp. [hospital] called res. has fractured L hip and admitted to [name of local hospital]." Documentation was lacking in the Nurse's Notes to indicate a follow-up investigation into the fall on 4/16/11. Nurse's Notes indicated the resident was readmitted to the facility on 4/25/11. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Care Plan related to potential for falls indicated the following Approaches were handwritten additions: 4/25/11 WBAT [weight bearing as tolerated]; 4/26/11 Assist resident to lie down when fatigued. Nurse's Notes for 5/24/11 at 10:35 a.m., indicated, "Responded to alarm sounding from room. Res found on L side on fall mat. [Symbol for no] apparent injury....Staff to encourage resident to stay out of room when [arrow pointing up] in wheel chair...." The following approaches, dated 5/24/11, were handwritten onto the Care Plan: Encourage res to stay out of room when [arrow pointing up] in W/C" and "Enc. resident to call for assist to transfer." [The interventions of "Encourage resident to sit at nurses station if out of bed" and "Provide and encourage resident to use call light and get assist with ambulation" were already part of the Care Plan.] Nurse's Notes for 5/25/11 at 8:30 a.m., indicated, "F/U [follow-up] fall of 5/24/11. Resident has an alarm which sounded. He had been in W/C prior to fall - was sitting @ nurses desk just prior to fall. He had just returned from therapy - was in W/C near nurse's desk. He wheeled himself to room tried to transfer self to bed. Mat was in place & prevented serious injury. We will cont [continue] 30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	" [minute] [checks] & ins [instruct] resident to ask for assist if he wants to lie down." Nurse's Notes for 5/26/11 at 3:55 p.m. indicated, "Res was at nursing station after therapy. This nurse started down hall [symbol for with] cart. res. must have wheeled himself down hall to [Resident J's room number] to bathroom and fell. ROM [range of motion] was done on bil [bilateral] extremities all WNL. Res. states he put himself on toilet and fell...." Nurse's Note for 5/26/11 at 5:30 p.m. indicated, "Res to wear non-skid socks even in shoes so if he takes his shoes off he will still be protected. Lab for C-diff [Clostridium difficile, a bacteria that causes diarrhea]." Documentation in the Nurse's Notes was lacking to indicate a follow-up note to the fall on 5/26/11. Handwritten onto the Care Plan Approaches on 5/26/11, and then lined through with the word "duplicate" written in, was: Gripper socks." Other additions to the Care Plan Approaches for 5/26/11 indicated: "Stool for C-diff" and "D/C [discontinue] Surfak [laxative]." Nurse's Notes for 5/31/11 at 10:15 [a.m. or p.m. not specified] indicated, "Nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	student came to nurses station, stating that Res pressure alarm was alerting, [symbol for with] Res found on floor next to the bed on his R side. When I entered the room another nurse was present getting pt's [patient's] vital signs....Turned Pt to his back, when he stated his L leg was causing him some pain, that's when I noticed that the left leg was inverted inwards....Pt had recently been out for a recent fracture to his L hip...." Nurse's Notes indicated the resident was transported to the hospital by emergency services. Nurse's Notes for 6/1/11 at 9:00 a.m. indicated, "F/U yesterday's fall. Resident was up in W/C prior to fall. He had been to breakfast in DR [dining room] He had toileted [symbol for after] breakfast & was sitting in W/C in hall [symbol for with] alarm in place. He was able to propel self in W/C. He is presently @ hospital. Will evaluate fall interventions upon return." Nurse's Notes for 6/4/11 at 5:15 p.m., indicated the hospital notified the facility the resident expired at the hospital. During interview on 6/14/11 at 12:45 p.m., the Director of Nursing (DON) indicated she investigated all falls. The DON indicated her investigation was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	described in the Nurse's Notes, usually with the introduction of, "Follow-up to fall of" with the date. She indicated new interventions would also be listed on the Care Plan. During interview on 6/14/11 at 1:55 p.m., the DON indicated it was a "balancing act" with Resident J "between maintaining his independence and preventing falls." She indicated the resident liked to go in his room and watch TV. She indicated the resident would stay busy during the day going to meals and therapy and activities. She indicated the resident would never stay long in activities. She indicated the resident's daughter wanted him up out of bed, and sometimes the resident was tired and wanted to lie down. This federal tag relates to Complaints IN00091279 and IN00091858. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0328 SS=G	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on interview and record review, the facility failed to ensure the resident at risk for low levels of oxygen in the blood was assessed to monitor use of oxygen for maintaining blood oxygen levels above 90% as ordered by the physician for 1 of 1 resident reviewed related to maintaining blood oxygen levels in a sample of 10 (Resident E) Resident E's respiratory condition declined, he required hospitalization for pulmonary edema and acute respiratory distress, and he expired at the hospital. Findings include: The closed clinical record for Resident E was reviewed on 6/14/11 at 2:50 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and acute exacerbation of COPD. Physician's orders for May 2011 included, but were not limited to, "O2 [oxygen] @	F0328	The facility does ensure that residents receive proper respiratory care and treatment. The facility does monitor the oxygen levels for those residents receiving oxygen as ordered by the physician.Resident E was discharged from the facility on 5/23/11. The medical records of all residents receiving oxygen have been reviewed by the Nursing Managers to ensure that those residents who have experienced low oxygen saturation levels were assessed and monitored to maintain oxygen saturation levels as ordered by the physician.Licensed nursing staff were inserviced on the facility's policy and procedure regarding accurate assessment of the residents that are receiving oxygen. Nursing Managers will review the 24-hr shift reports daily for all residents receiving oxygen and noted to have an O2 sat below 90%. The medical record will be reviewed as necessary to ensure that the appropriate assessments have been completed and interventions are	07/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2L [liters] via N/C [nasal canula] as needed to keep O2 sats [saturation] above 90%" and "Ventolin HFA 90 mcg [microgram] inhal [inhalant] [fast acting bronchodilator], give 1 puff every 4 hours as needed." The resident's Care Plan, with Problem Onset date of 8/3/10, indicated, "Potential risk for altered respiratory function r/t [related to] COPD, immobility, and hx [history] of recent pneumonia. Approaches included, but were not limited to, "O2 2 L/M [liters per minute] via nasal canula PRN [as needed] to keep O2 sats above 90%." "Nursing Follow-Up Documentation," dated 5/21/11, indicated, "Brief Description: Lung sounds and SOA [shortness of air]. Finished on AB [antibiotic] and Prednisone 5/21." Documentation on the note on 5/21/11 at 2:00 p.m., indicated, "O2 [oxygen] 80 Res [resident] C/O [complained of] being SOA, [symbol for no] C/O pain, vent huff [respiratory treatment] given, slight WH [wheeze] throughout all lung fields. Will cont. [continue] to mont [monitor]." Another "Nursing Follow-Up Documentation," also dated 5/21/11, indicated, "Brief Description: Mont. lung sound & SOA." Documentation on this		in place.Findings will be reported to the DON weekly. DON will ensure additional training or counseling is provided as necessary.A report of the above findings will be submitted to the QA Committee quarterly until such time that the committee deems a reduction in the audits is warranted.DON and Administrator to monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	note, on 5/22/11 at 12 midnight indicated, "Crackles lower lungs, both sides, [symbol for no] SOA. Res resting abed @ this X [time], will continue to monitor." Nurse's Notes on 5/22/11 at 12:00 p.m. [noon] indicated, "N.O. [new order] to mont. O2 sats [saturations] Q [every] shift. Res cont to have [arrow pointing down] O2 sats below 90. Vent huff given & O2 applied. < [before] O2 was 61 > [after] O2 then went [arrow pointing up] to 92. Will cont. to mont. Fam [family] and MD [doctor] notified." The "Nursing Follow-Up Documentation," dated 5/21/11, indicating, "Brief Description: Mont. lung sound & SOA," including documentation on 5/22/11 at 2:00 p.m. indicated, "Cont [symbol for with] slight WH throughout. Res having SOA this a.m. [morning] O2 was at 61, give vent huff & applied O2, went [arrow pointing up] 91 [sic]. Will cont to mont." Documentation on 5/22/11 at 9:00 p.m., indicated, "[symbol for no] S/S [signs and symptoms] of resp [respiratory] distress or SOA." Documentation on 5/23/11 at 1:00 a.m., indicated, "Res sitting upright on side of bed [symbol for with] some wheezing noted [arrow for upper] [arrow for lower] lobes. Cont [symbol for with] [illegible			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	word] lip breathing. [Symbol for no] S/S resp distress noted. Resp even & non-labored @ present X. Res O2 not in place. Re-applied per nurse & educated resident on importance of O2 via N/C [nasal canula]. V/S [vital signs] 116/70 - 96 [heart rate] - 24 [respirations] 96.4 [temperature]. O2 64% [symbol for after] O2 applied [symbol for increased] 90 - 92%. [Symbol for no] C/O pain/discomfort voiced @ present X. Skin W/D [warm/dry]. Will cont to monitor." The Medication Record for May 2011 indicated the resident oxygen saturation level on the 10:00 p.m. to 6:00 a.m. shift was measured at 90%. Documentation did not indicate the specific time the saturation was measured. Documentation failed to indicate the resident was monitored to ensure he continued to use the oxygen from 1:00 a.m. until 8:00 a.m. The next Nurse's Note was 5/23/11 at 8:00 a.m., and indicated, "Res C/O SOA, keeps taking O2 off. O2 57%, put N/C on. 164/102 [blood pressure] P [pulse] 100, T [temperature] 97.4 R [respirations] 36 very shallow. Monitoring O2 and resident keeping O2 NC on. Contacted [name of x-ray service] ordered CXR [chest x-ray]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	d/t [due to] [arrow point up] congestion, lung sounds crackles and rales." Nurse's Notes on 5/23/11 at 8:20 a.m., indicated the resident declined, an oxygen rebreather mask was used, and the oxygen setting increased to 5 and then 6 liters per minute, and the oxygen saturation increased to 84%. The physician ordered the resident be sent to emergency room, and the resident was admitted to the hospital with pulmonary edema and acute respiratory distress. Notes indicated the hospital notified the facility the resident expired on 5/25/11. During interview on 6/14/11 at 3:00 p.m., the Director of Nursing indicated the resident tended to take his oxygen by nasal canula off and on. She also indicated she would check on further information on the assessment of the resident between 1:00 a.m. and 8:00 a.m., and no further information was provided at the time of exit from the facility on 6/14/11 at 5:05 p.m. This federal tag is related to Complaint IN00091858. 3.1-47(a)(6)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE